Minutes of the Special Meeting of the Board of Directors of the Cook County Health and Hospitals System (CCHHS) held Wednesday, February 27, 2019 at the hour of 3:00 P.M. at 1950 West Polk Street, in Conference Room 5301, Chicago, Illinois.

I. Attendance/Call to Order

Chair Hammock called the meeting to order.

Present:	Chair M. Hill Hammock and Directors Mary Driscoll, RN, MPH; Ada Mary Gugenheim; Mike Koetting; David Ernesto Munar; Heather M. Prendergast, MD, MS, MPH; Layla P. Suleiman Gonzalez, PhD, JD ; and Sidney A. Thomas, MSW (8)
Telephonically Present:	Director Mary B. Richardson-Lowry (1)
Absent:	Directors Hon. Dr. Dennis Deer, LCPC, CCFC and Robert G. Reiter, Jr. (2)

Additional attendees and/or presenters were:

Linda Follenweider – Chief Operating Officer, Correctional Health
Terry Mason, MD – Cook County Department of Public Health
Jeff McCutchan –General Counsel
Connie Mennella, MD – Chair, Department of Correctional Health
Letitia Reyes-Nash – Director of Programmatic Services and Innovation
Mary Sajdak – Chief Operating Officer of Integrated Care
Deborah Santana – Secretary to the Board
John Jay Shannon, MD – Chief Executive Officer
Diane Washington, MD – Executive Director of Behavioral Health

II. Public Speakers

Chair Hammock asked the Secretary to call upon the registered public speakers.

The Secretary responded that there were none.

III. Recommendations, Discussion / Information Items

A. Strategic planning discussion

- **Health Equity and Social Determinants** (Attachment #1)

Dr. Terry Mason, Chief Operating Officer of the Cook County Department of Public Health, provided an overview of the presentation on Social Determinants of Health, which included information on the following subjects:

- Definitions of Social Determinants of Health and Health Equity
- Structural Racism
- Table – Life expectancy, by race and sex: United States, 1999-2013
- 1934-1968: FHA Mortgage Insurance Requirements Utilize Redlining
- Racial/Ethnic Inequities in Neighborhood Opportunities
- Infant Housing and Food Insecurity
- Adverse Pregnancy Outcomes Reporting System (APORS)
- Food/Housing Insecurity Among APORS Families

A. Strategic planning discussion

- **Health Equity and Social Determinants (continued)**

- Successful Approaches to Advance Health Equity
- Mobilize Data to Advance Health Equity
- Active Transportation
- Worker Health
- Good Food Purchasing Program
- Lead Poisoning Prevention
- Sexually Transmitted Infections
- Summary

Mary Sajdak, Chief Operating Officer of Integrated Care, provided an overview of the presentation on Impacting Social Determinants of Health, which included information on the following subjects:

- Impact 2020 Recap – Progress and Updates: Social Determinants of Health
- Additional Activities Linked to Social Determinants
- Additional Activities Underway
- Social Determinants – Facilitators
- Health Risk Screening
- FY2020-2022 – Opportunities
- Strategic Planning Recommendations

During the discussion of the information on Health Risk Screening, Director Suleiman Gonzalez requested data on the percentage of the high-risk patient population who are limited-English speakers. Additionally, she requested that the data be broken down by ethnicity. Ms. Sajdak responded that the information will be provided.

- **Extramural Funding** (Attachment #2)

Letitia Reyes-Nash, Director of Programmatic Services and Innovation, provided an overview of the presentation on Extramural Funding, which included information on the following subjects:

- Overview of Department – Mission, Organizational Chart, Areas of Responsibility, Budget
- Impact 2020 Recap – Status and Results
- The Future – Environmental Scan of Market, Trends, Best Practices
- Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis
- Strategic Planning Recommendations

- **Justice Involved / Correctional Health** (Attachment #3)

Linda Follenweider, Chief Operating Officer of Correctional Health provided an overview of the presentation on Correctional Health: Adult and Juvenile. Dr. Connie Mennella, Chair of Correctional Health, provided additional information. The presentation included information on the following subjects:

A. Strategic planning discussion

- **Justice Involved / Correctional Health (continued)**

- Operations and Services Overview
- Behavioral Health
- Substance Use Disorder Treatment: Narcan
- Physical Medicine
- Nursing Services
- Offsite Specialty Services
- CQI and Risk Management
- Women's Health Services
- Patient Feedback
- Radiology
- Juvenile Temporary Detention Center (JTDC)
- JTDC Milestone Activities
- Impact 2020 Recap – Status and Results
- The Future – Environmental Scan of Market, Best Practices and Trends
- SWOT Analysis
- Strategic Planning Recommendations

- **Behavioral Health** (Attachment #4)

Dr. Diane Washington, Executive Director of Behavioral Health, provided an overview of the presentation on Behavioral Health, which included information on the following subjects:

- Vision 2015
- Impact 2020 Recap – Status and Results
- The Future – Environmental Scan of Market, Best Practices and Trends
- SWOT Analysis
- Strategic Planning Recommendations
- Behavioral Health Initiatives
- Next Steps

IV. Adjourn

As the agenda was exhausted, Chair Hammock declared that the meeting was ADJOURNED.

Respectfully submitted,
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXX
M. Hill Hammock, Chair

Attest:

XXXXXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

Requests/Follow-up:

Request: A request was made for data on the percentage of the high-risk patient population who are limited-English speakers, broken down by ethnicity. Page 2

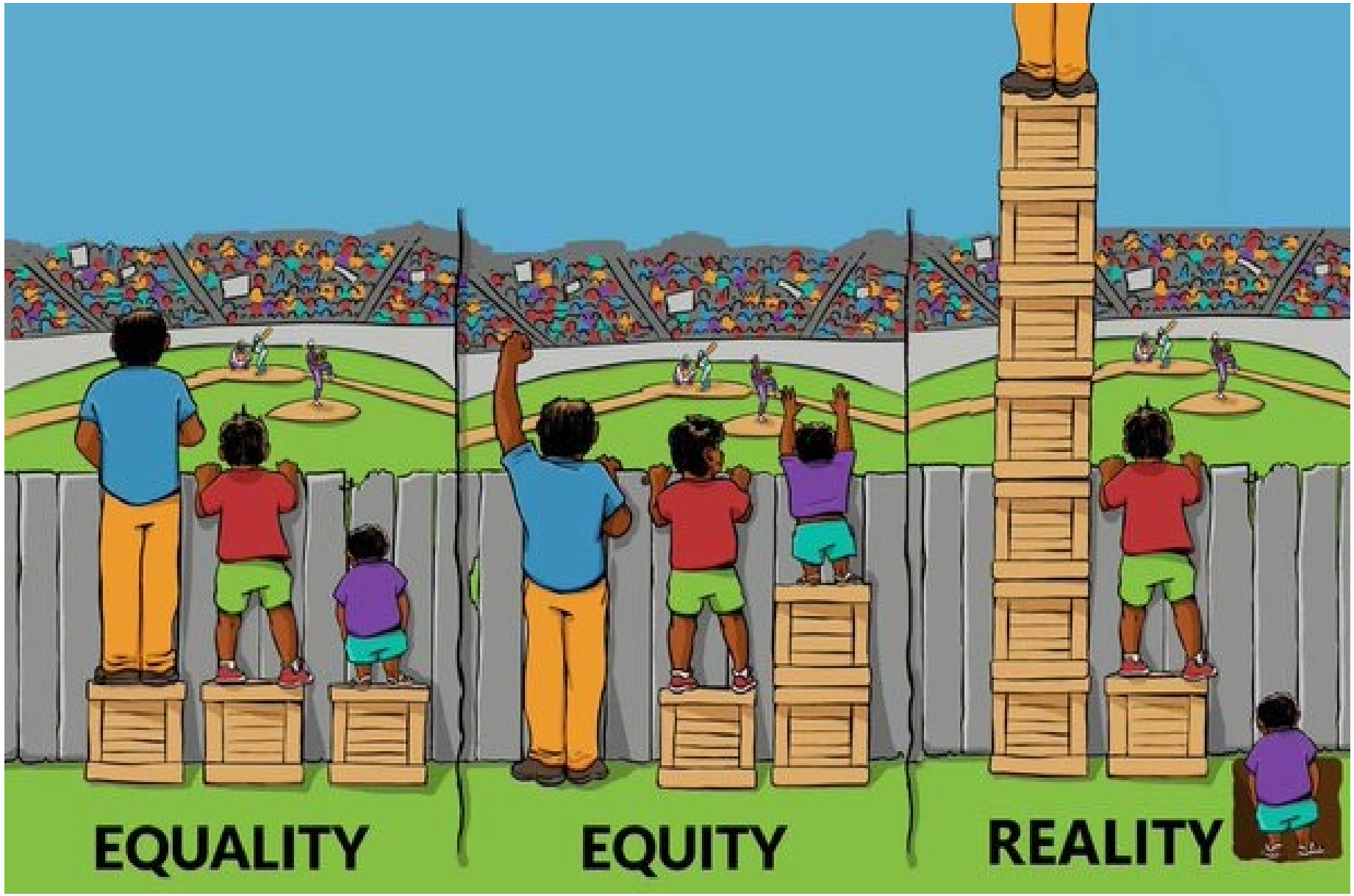
ATTACHMENT #1

Social Determinants of Health

Terry Mason, MD
Chief Operating Officer
Cook County Department of Public Health

February 27, 2019

COOK COUNTY HEALTH


EQUALITY
EQUITY
REALITY

Social Determinants of Health

- The social determinants of health are the conditions in which people are born, grow, live, work and age.
  - Health care
  - Affordable housing
  - Healthy food
  - Safe, walkable neighborhoods
  - Healthy work environments
  - Living wage
- Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.

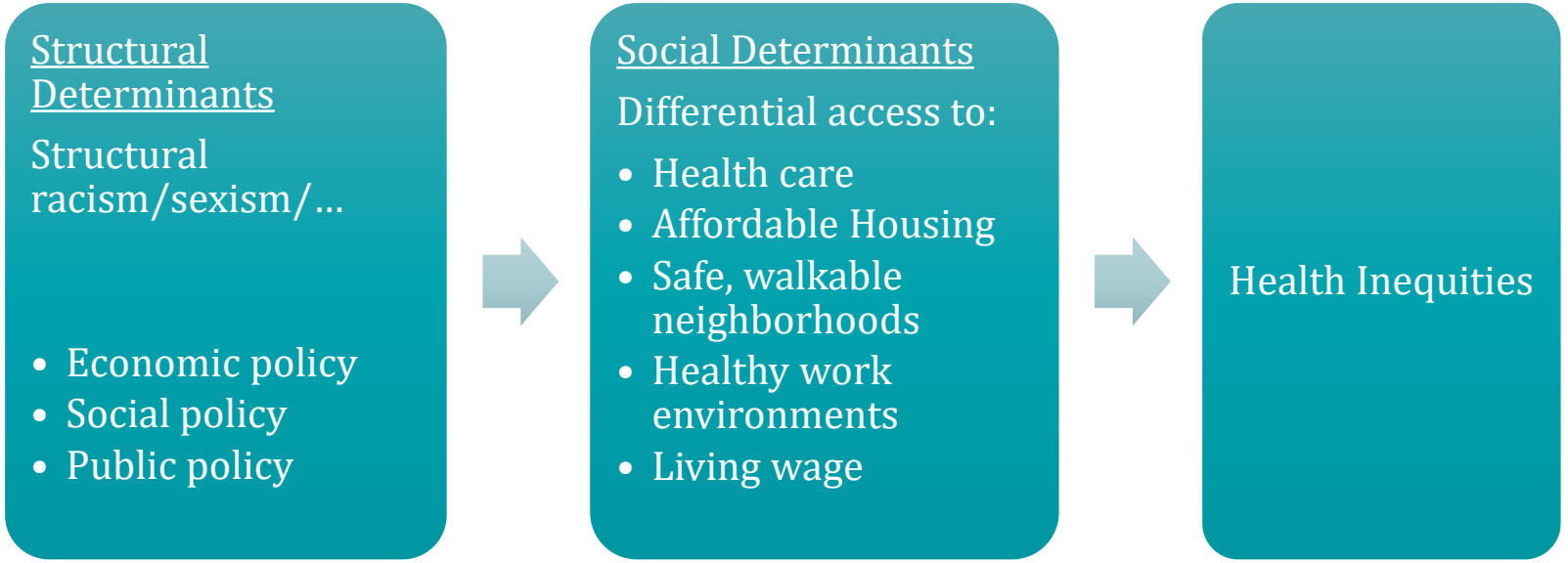
Commission on Social Determinants of Health (CSDH), Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. 2008, World Health Organization: Geneva.

Health Equity

"Health equity is the assurance of the conditions for optimal health for all people.

Achieving health equity requires valuing all individuals and populations equally, recognizing and rectifying historical injustices, and providing resources according to need."

How Do Health Inequities Arise?



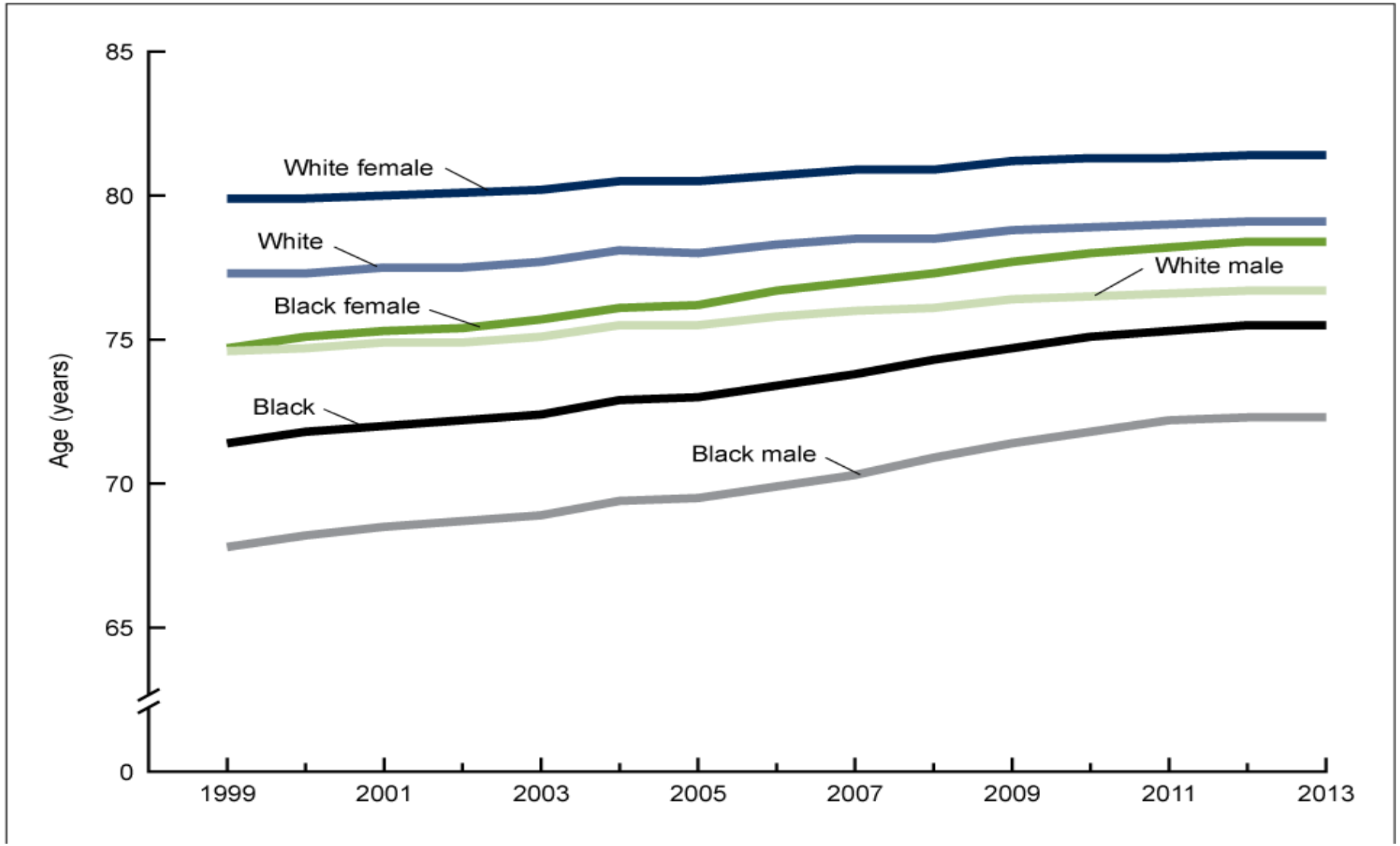
Modified from Solar, O., & Irwin, A. (2007). A conceptual framework for action on the social determinants of health.

Structural Racism

A fundamental cause of health inequity, associated with imbalances in political power throughout society… Structural racism perpetuates residential segregation, concentrated poverty, disinvestment in neighborhoods, and targeting neighborhoods for toxic waste— all issues related to serious health outcomes. (NACCHO 2016)

National Association of County and City Health Officials (NACCHO). (2016). *Health Inequity: A Charge for Public Health*. Retrieved from https://nnphi.org/wp-content/uploads/2016/09/na16-whitepaper-final-print.pdf

Figure 1. Life expectancy, by race and sex: United States, 1999–2013



https://www.cdc.gov/nchs/data/databriefs/db218_fig1.png

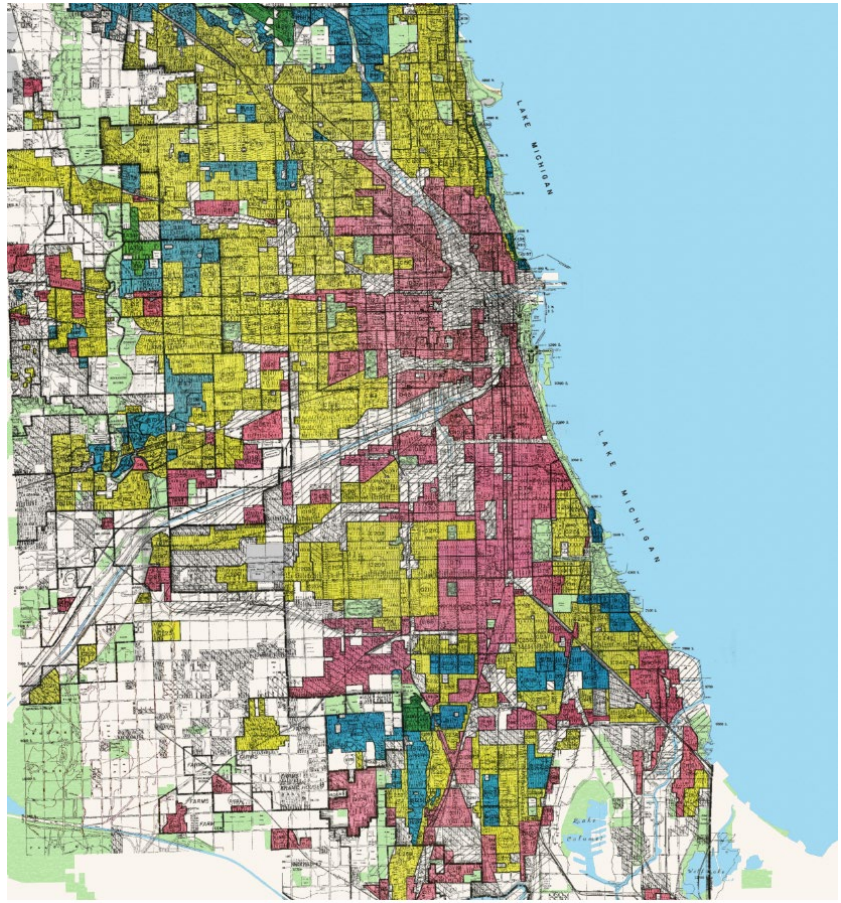
1934–1968: FHA Mortgage Insurance Requirements Utilize Redlining:

"The FHA also explicitly practiced a policy of "redlining" when determining which neighborhoods to approve mortgages in.

"… color-coded maps indicating the level of security for real estate investments… appraisers divided neighborhoods by categories including occupation, income and ethnicity of inhabitants:

C (yellow) were neighborhoods that were "definitely declining." Generally sparsely populated fringe areas that were typically bordering on all black neighborhoods.

D (red) (hence the term "red-lining") were areas in which "things taking place in 3 ("C") had already happened." Black and low income neighborhoods were considered to be the worst for lending".



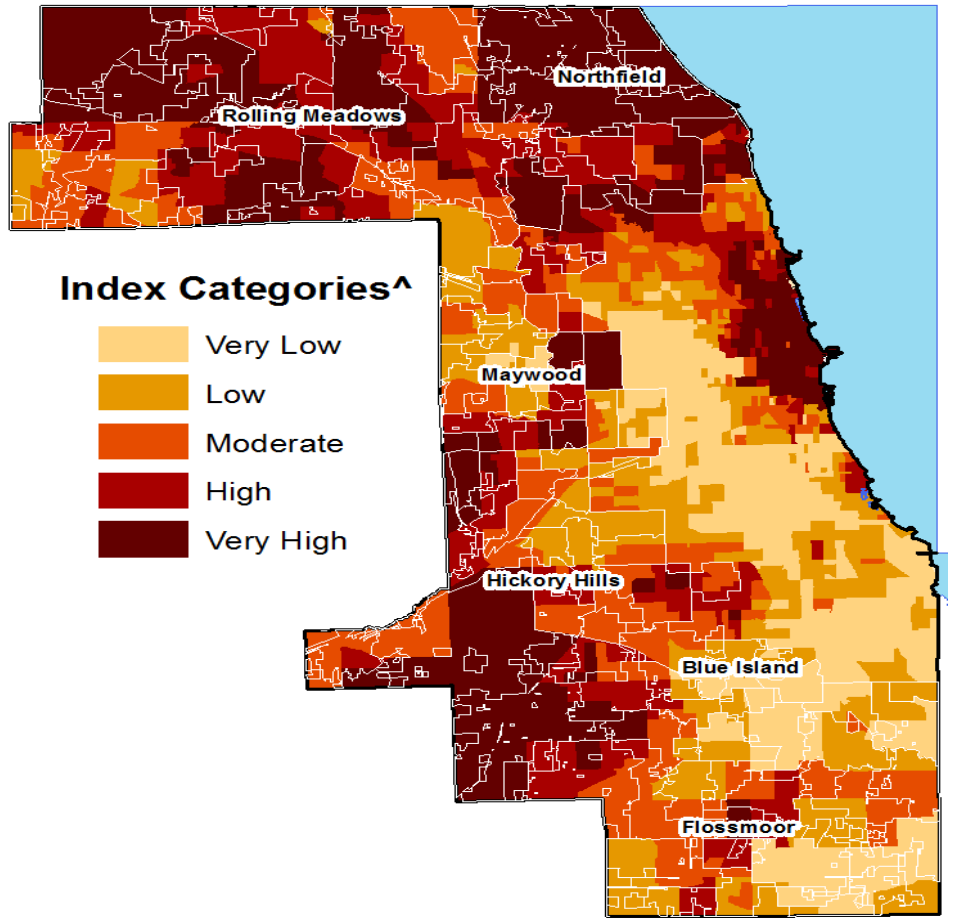
1934: Federal Housing Administration Created. (n.d.). Retrieved February 22, 2018, from http://www.bostonfairhousing.org/timeline/1934-FHA.html

Racial/Ethnic Inequities in Neighborhood Opportunities

Race/Ethnicity of Child by Neighborhood Opportunity Level

COI Level	NH Asian	NH Black	NH White	Hispanic
Very Low	**2%**	**51%**	**2%**	**31%**
Low	10%	29%	10%	35%
Moderate	25%	11%	21%	20%
High	30%	5%	26%	8%
Very High	32%	4%	41%	5%

Childhood Opportunity Index by Census Tract
Cook County-IL (Metro Area)*, 2007-2013**



^ Each Census Tract is shaded according to its Opportunity Index category representing childhood opportunity levels ranging from "very low" to "very high" relative to the other tracts in the Chicago-Joliet-Naperville , IL-IN -WI Metro Area.

Infant Housing and Food Insecurity

COOK COUNTY HEALTH

All new APORS families visited 10/2017 – 07/2018

- Address change (past 12 mo.) or temporary housing
- Food pantry referral

Adverse Pregnancy Outcomes Reporting System (APORS)

Eligibility

- Cook County resident
- No income eligibility
- Birth defect/congenital anomaly

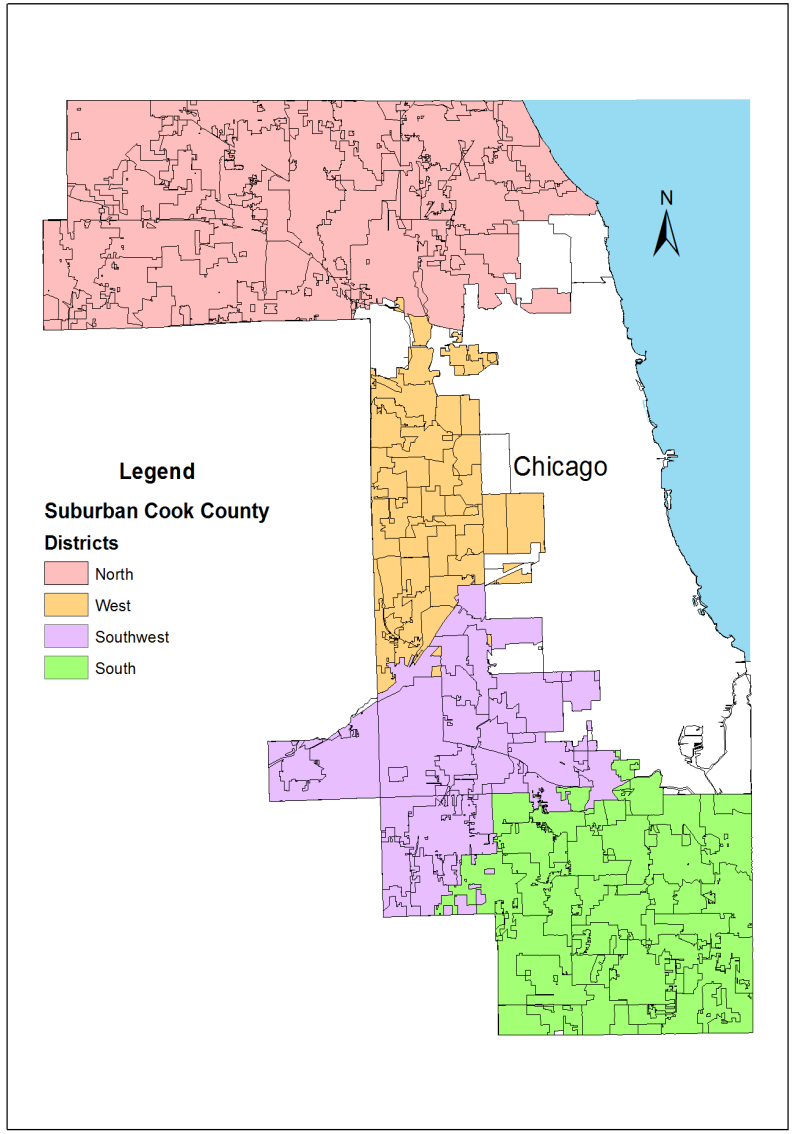
APORS Criteria:

- Born at less than 31 weeks gestational age
- Infant was part of a triplet, or higher birth
- Positive drug toxicity diagnosis, signs/symptoms, or mother admits to drug use during pregnancy
- Diagnosed with a congenital anomaly; a serious birth defect

Food / Housing Insecurity Among APORS Families

SCC District

	North	West	Southwest	South
APORS Families	182	150	151	114
Address Change or temporary housing	9	7	16	13
Food Pantry Referral	9	18	6	21



How Can We Advance Health Equity? Some successful approaches

Strengthening health equity… means **going beyond the contemporary concentration on the immediate causes of disease.**

WHO Commission on Social Determinants of Health. (2007). Achieving health equity: from root causes to fair outcomes: Commission on Social Determinants of Health, Interim statement.

COOK COUNTY HEALTH

Mobilize Data to Advance Health Equity

- Surveillance of health equity policies across 140+ school districts in SCC
- Explore potential analysis of suburban school discipline reports for racial and other inequities

Active Transportation

- Summit was selected as the recipient for the CBS EcoMedia project
- Funding from CBS will support construction of a sidewalk, adjacent to a middle school
- Construction to take place in 2019

Worker Health

- Participated in UIC SPH Healthy Work Collaborative
- Strengthened relationships with two worker advocacy orgs
- Coordinating efforts around County's Min Wage and Earned Sick Leave Ordinances
- Glenview opted-in to both ordinances, impacting 5,725 workers (Jan 2019)

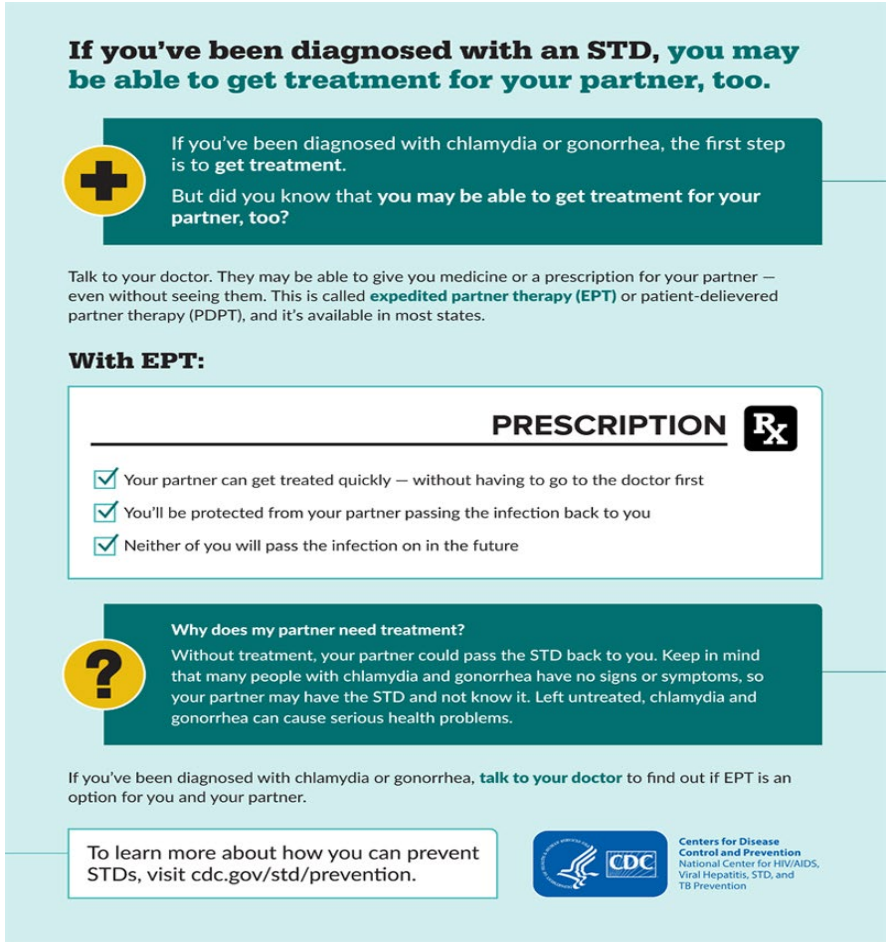
Good Food Purchasing Program

- Cook County resolution adopted in May 2018
- Established CCDPH as convening agency for Task Force
- Baseline assessment expected to be initiated in 2019

Lead Poisoning Prevention

- Participating in pilot program exploring automatic eligibility for Early Intervention
- 57 units remediated in 2018
- Provided comments to influence rules for Lead Poisoning Prevention Act

Sexually Transmitted Infections



- Sharing data
- Educating the public and providers
- Encouraging more screening for STDs
  - Especially chlamydia and gonorrhea
  - Especially in those 18-24 years of age
- Urging providers to learn about and use Expedited Partner Therapy
- Making sure cases receive treatment after being diagnosed with STIs
- Emphasizing prevention
  - Condom availability throughout CCH
  - Correct and consistent condom use

In Summary

Long history of discrimination and racist practices affecting residents of the near west and southern parts of Cook County

The evidence is clear that racism is deeply entrenched and continues to affect the opportunities available to people of color

This has resulted in areas of concentrated poverty and low opportunity

As a result, populations residing in those areas suffer from disproportionately poor health outcomes

Must improve health equity and correct Social Determinants of Health

Thank You

COOK COUNTY HEALTH

Strategic Planning FY 2020-2022

Impacting Social Determinants of Health

Mary Sajdak, COO of Integrated Care

February 27, 2019

COOK COUNTY HEALTH

Impact 2020 Recap

Status and Results

- Deliver High Quality Care
- Grow to Serve and Compete
- Foster Fiscal Stewardship
- Invest in Resources
- Leverage Valuables Assets
- **Impact Social Determinants**
- Advocate for patients

COOK COUNTY HEALTH

Impact 2020

Progress and Updates-Social Determinants of Health

Name	Status
Ensure continued access for uninsured patients	• Director of Carelink hired 11/18 • Monthly meetings with joint agenda settings established • Carelink membership stable at 31,500 • # of Carelink members in Care Coordination 326 • Understanding admission reasons, ambulatory visits to refine care coordination approach
CCDPH data to plan intervention to improve population health	In Progress

Impact 2020

Progress and Updates-Social Determinants of Health

Name	Status
Partner with other organizations to impact social determinants of health	• Food as Medicine **Greater Chicago Food Depository** food trucks at 13 sites • Contract in process for nutritional support for at-risk CCH patients and CountyCare members with **Independent Living Systems** • Partnership established with **Black Oaks**, planning for 2019 underway • Completed housing 33 units for **Housing Forward**, 30 for **Illinois Housing Development Authority** (IHDA) • Training for care coordination for Coordinated Entry System and assessments • Securing 56 vouchers for **Housing Authority for Cook County** (HACC) • Outreach started on **Flexible Housing Pool** initiative
Develop Care Coordination	Developed, 200 care coordination team members in multiple sites

Additional Activities Linked to Social Determinants

Focus Area	Activities	Results
Linkages to Mental Health (MH)/Substance Use Disorder (SUD) Services	• Specialized discharge planning for those with medical complications of Opioid Use Disorder (OUD) • Access to outpatient services via Behavioral Health Access Line (BHAL) • Warm hand-offs for those in pretrial area at 26th and California with MH/SUD	• 60 patients per month • 500 to 600 BHAL referrals per month to ambulatory providers • Approximately 80 referrals per month to MH and SUD providers
Access to care	• Additional support for Patient Support Center through Chicago Lighthouse	• 277,279 primary and specialty care appointments were made in in 2018. (30,011 Chicago Lighthouse) • Initiation of concierge services for patients
Social Support	• Utility Assistance • Expansion of Community Health Worker activities of linkages to community based organizations	• $180,000 in grants, average grant size $250 to $500.

Additional Activities Underway

Focus Area	Activities	Results

Income/Economic Support	• Legal Aid Foundation support to resolve Health Harming Needs
	  • Access to public benefits
	  • Application for SSI and SSDI
		2018 Referrals
		256 Public Benefits
		44 Housing
		36 Family Law
		80 ADAPT
		22 Disability Cases (SSI/SSDI)

Transit	• Rides for discharged patients, ED patients, ACHN and methadone	110,000 rides since 9/17 95% on time arrival 27.4 minutes for on-demand rides 8821 bus passes for methadone treatment

Social Determinants

Facilitators

- A funding stream to enable this work this includes system resources as well as grant funds
- Health System willingness to engage for non- traditional service/support
- Staff willing to tackle the complexities associated with this work
- Willing external and internal partners

Health Risk Screening

COOK COUNTY HEALTH

Health Risk Screening

Identification

Screening for Social Determinants of Health

- ED, Inpatient Units, Ambulatory Centers, Bond Court

Referrals from staff, physicians, CountyCare

Data review -- claims, utilization information

Results

- 17,093 CountyCare members were screened during 2018

Health Risk Screening

Self-Reported Data

Question	Potential Risk	Question	Potential Risk Factor
Last PCP visit >1 yr	(5%)	Abuse history	(3%)
Lack of transportation for medical appts	(20%)	Afraid of family member	(.6%)
Problems obtaining or paying for meds	**(9%)**	No one to help you for a few days	**(26%)**
Overall health	**Fair (22.6) Poor (8.6%)**	Need help getting food	**(18%)**
Presence of MH condition	**(17.1%)**	Help with housing	**(10.9%)**
Presence of SUD	**(2.9%)**	Help with utilities	**(15.3%)**
Unstable Living Situation	**(2.0%)**	Help with clothing	**(12.1%)**

Health Risk Screening

Frequency of Risk Indicators

	1-3 Indictors %	4-6 Indicators %	7 or more Indicators %	Population Size
Chronic MH	43.3 %	39.7%	16.8%	2,446
Chronic SUD	26.4%	43.0%	30.4%	702
MH/SUD	16.0%	40.8%	43.0%	411
Total Population	80.4%	16.0%	3.5%	17,093

FY2020-2022

Opportunities

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Impact Social Determinants/Advocate for Patients FY2020-2022 Strategic Planning Recommendations

2018 Opportunities

- External partnerships are only partially defined; not clear how well they work/support the patients or members
- Engagement of physicians and medical home team members regarding CCH capabilities
- Being able to evaluate what really works for whom

Impact Social Determinants/Advocate for Patients FY2020-2022 Strategic Planning Recommendations

Integrated Care Short-Term Plans

- Meet or exceed targets for all funded projects related to housing, opioid abuse, linkages to treatment for SMI
- Secure ongoing funding for MH/SUD activities when grant funding expires e.g. recovery coaches, AOT Assisted Outpatient Treatment (AOT) program, etc.
- Catalog existing activities regarding tobacco cessation, nutritional support, exercise and risk reduction for scalability and ease of referrals
- Identify top 3 social/community needs of CCH supported patients and identify strategy(ies) to meet needs
- Partner with CCDPH on one mutual project (housing for children at risk)
- Develop an understanding of patient approach and related successful interventions
- Develop and present a housing model for CCH patients

Impact Social Determinants/Advocate for Patients FY2020-2022 Strategic Planning Recommendations

Organizing for Impact and Sustainability

- Create a coordinating committee -- success will depend on cross-department collaboration and coordination
- Identify working definitions for social determinants of health, which ones may be in the purview of CCH departments and strategies for others that may have significant impact
  - Complete gap analysis and provide recommendations
  - Document resource requirements, training etc.
  - Enter into discussions to support collaboration
- Review information from cataloging existing programs and determine next steps
- Complete implementation of social service data base

Thank You

COOK COUNTY HEALTH

ATTACHMENT #2

Strategic Planning FY 2020-2022

Office of Programmatic Services and Innovation

February 27, 2019

Leticia Reyes-Nash

Director of Programmatic Services and Innovation

COOK COUNTY HEALTH

Overview of Department

Mission, Organizational Chart, Areas of Responsibility, Budget

COOK COUNTY HEALTH

Overview of Department

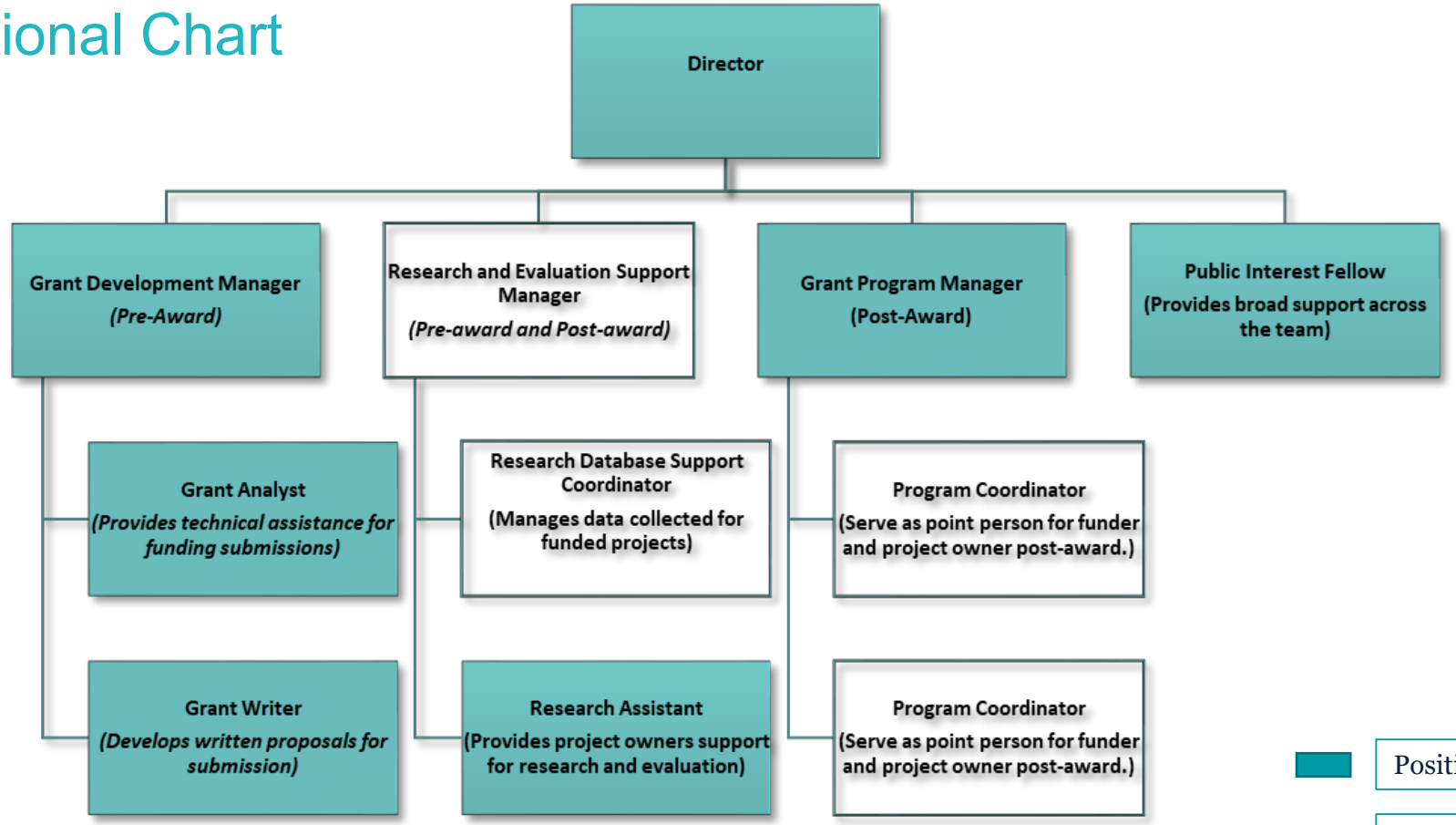
Mission

Identify and pursue opportunities to achieve strategic goals and objectives through:

- Pursuing extramural funding to implement innovative programs, and evidence-based best practices;
- Developing and leveraging groundbreaking partnerships;
- And fostering a collaborative learning environment.

Overview of Department

Organizational Chart



Overview of Department

Areas of Responsibility

- Monitor funding and policy environment to identify opportunities for funding or partnerships.
- Develop innovative revenue opportunities to support strategic objectives.
- Create innovative partnerships and programs that can be piloted within CCH.
- Identify and apply for funding opportunities from public and private funders.
- Provide post-award support including, project management, fiscal and administrative support for project owners.
- Leverage internal resources to support new grant programs and research startup activities.
- Foster a collaborative learning community.

Overview of Department

Budget

2018 FTE	2018 Budget	2019 FTE	2019 Budget
6.0	$536,158	10.0	$887,765

Impact 2020 Recap

Status and Results

- Deliver High Quality Care
- Grow to Serve and Compete
- Foster Fiscal Stewardship
- Invest in Resources
- Leverage Valuables Assets
- Impact Social Determinants
- Advocate for Patients

COOK COUNTY HEALTH

Impact 2020

Progress & Updates

Focus Area	Name	Status (Complete/In Progress/Not Started/ Ongoing)	
3.2 Foster Fiscal Stewardship	Optimize Grant Revenue and Indirect Revenue	Complete	Developed internal infrastructure to receive and manage extramural funding. Secured $15 million in funds from federal and state governmental agencies, public and private foundations. (FY16-FY19)

Impact 2020

Progress & Updates

Focus Area	Name	Status (Complete/In Progress/Not Started/ Ongoing)	
6.3 Impact Social Determinants	Explore social determinant-grant related opportunities	Complete	Secured resources and partnerships to support: -Housing Linkage and Resources -Behavioral Health Services -Workforce Development -Justice Involved Partner Collaborations -Access to Fresh Produce

Impact 2020

Progress & Updates

Focus Area	Name	Status (Complete/In Progress/Not Started/ Ongoing)	
7.2 Advocate for behavioral health funding and legislation	Secure funding and partnerships	Complete	Secured over $12 million in funding to support Behavioral Health Monitoring funding environment and incubating projects to be responsive to upcoming opportunities

FY2020-2022

The Future

Environmental Scan of Market, Trends, Best Practices

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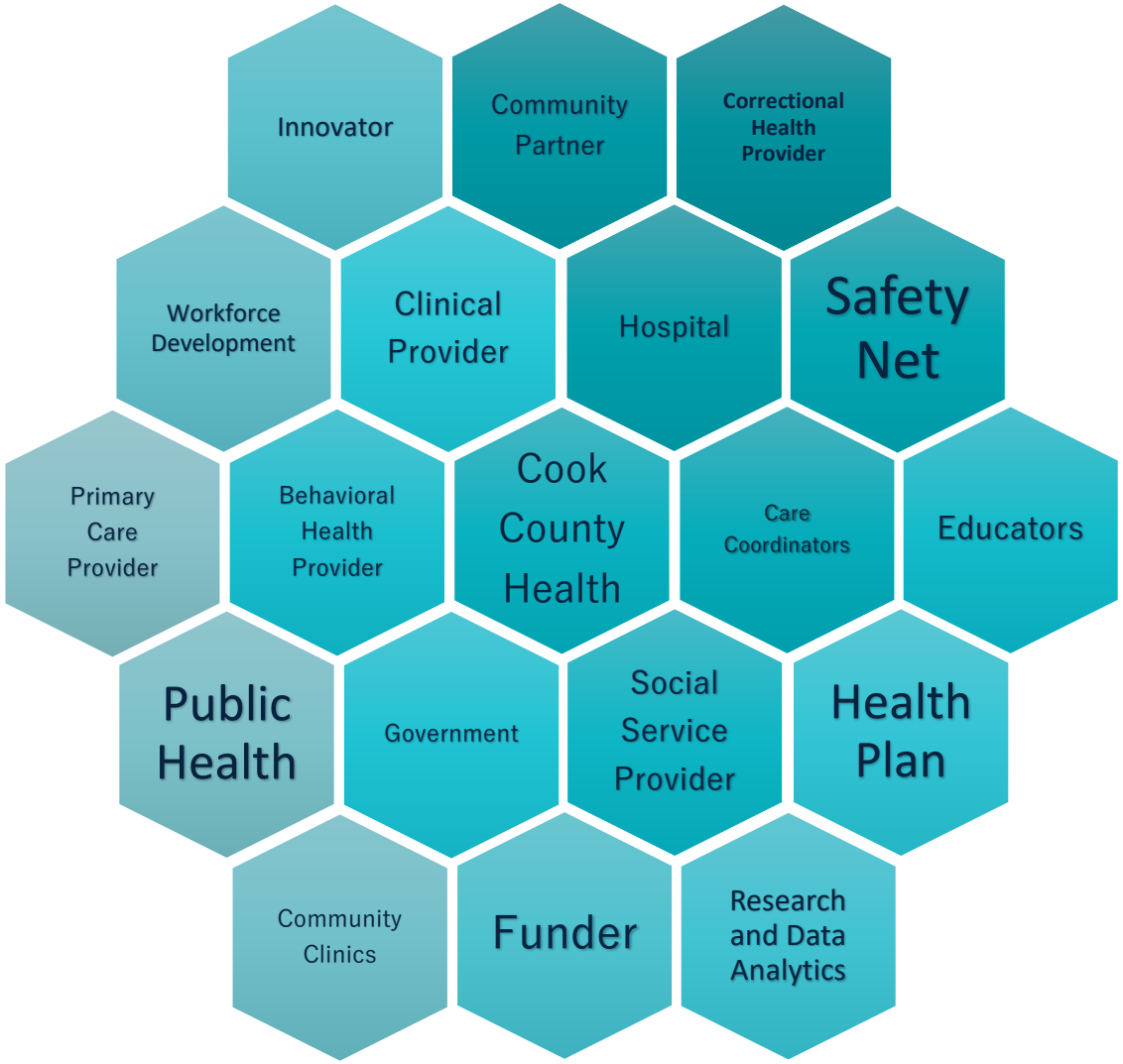
The Kaleidoscope



The Roadmap

"The Roadmap," *Health Leads*, 2018.13

Environmental Scan of Market

Grant Funding Sources Nationally

Federal Government
- Over $400B available annually
- Large grants (often $250K to $500K in size)

State/ City Government
- Declines in funding over the last several years
- Fewer and smaller than federal grants

Private Foundations
- $35B each year in funding
- $5B in health funding
- 20,000 grants awards

Environmental Scan of Market

Major Funding Trends in Grant making

Priorities	Description
Large Scale System Change	Funders are approaching grants as community or programmatic investments with a focus on solving specific system change issues and driving towards a big impact.
Cross-Sector Collaboration	Funders are making collaboration as a requirement for grant applicants. The goal is to promote connections across health care, social service and public health systems to meet the needs of individuals and communities.
Improving Health Outcomes	Funders are focusing on supporting collaborative, systems-based solutions that make measurable improvements in health outcomes and are replicable in other communities.

Environmental Scan of Market

Major Targeted Subject Areas and Examples of Funders for those Areas

Subject Area	Government Agencies	Private Foundations
Social determinants of health	USDA, CDC, HRSA, OMH, DHHS, IDHS (WIC), FDA, OMH, NIH, HUD	Chicago Community Trust (CCT), Michael Reese Health Trust (MRHT), Chase Foundation. Community Memorial Foundation, Aetna Foundation, Lloyd A. Frye Foundation, Otho Sprague Memorial Institute, United Way of Metropolitan Chicago, Field Foundation, Polk Brothers Foundation, Crown Family Philanthropies, Washington Square Health Foundation
Chronic Diseases	CDC, HRSA, DHHS, NIH, OMH	CCT, MRHT, Public Health Institute of Metropolitan Chicago, United Way of Metropolitan Chicago
Behavioral Health/ Substance Use Disorder (Opioids)	SAMHSA, HRSA, USDOJ, Illinois Criminal Justice Information Authority (ICJIA)	CCT, MRHT, Futures Without Violence, Lloyd A. Frye Foundation, Ortho Sprague Memorial Institute, Community Memorial Foundation
Justice-Involved Populations/ Violence Prevention	CDC, OMH, USDOJ, Justice Advisory Council, USDOJ, Illinois Criminal Justice Information Authority (ICJIA)	CCT, MRHT, Field Foundation, Arnold Ventures, MacArthur Foundation

Environmental Scan of Market

To stay up-to-date on best practices, we track these agency websites, industry associations, and professional networ

Source	Outlet
Funding Agencies	• Grants.gov • NIH, CDC, SAMHSA, HRSA
News Feeds/ Reports	• Politico Pulse • Modern Healthcare Daily Dose • Health Affairs Today • Annual reports from foundations • Chronicle of Philanthropy • The Nonprofit Times
Grant writing/nonprofit related list-serves	• FUNDED Grants Office • Philanthropy News Digest • Grantstation Insider

SWOT Analysis

Strengths, Weaknesses, Opportunities, and Threats

COOK COUNTY HEALTH

SWOT Analysis

Strengths

- Viewed as a *resource* within CCH
- Wide *skill-set*→ bring a wealth of past experience
- Revenue generators
- *Innovators*→ fusing together of disparate parts of the system
- Strong external partner relationships
- Mission
- Collaborative Research Unit

Weaknesses

- Inconsistent past practices for securing extramural funds
- Capacity issues→ need a clearer process to handoff projects to project leads
- Grant-related internal processes, still in development

Opportunities

- New state/city/county administrations
- Seminars for grant writing
- Stronger alignment with CCDPH
- Continued cross-sector partnerships
- Research and Innovation Summits
- Research Funding

Threats

- Uncertain future of funding
- Competing external organizations
- Funder priorities change

FY 2020-2022

Recommendations

COOK COUNTY HEALTH

Grow to Serve and Compete
FY2020-2022 Strategic Planning Recommendations

Foster Partnerships With CountyCare

- Align efforts to address Social Determinants of Health
- Develop innovative projects that leverage Medicaid to support Social Determinants of Health

Identify funding opportunities to support workforce development

- Apply for funding opportunities

Foster Fiscal Stewardship
FY2020-2022 Strategic Planning Recommendations

Optimize current funding trends

- Continue obtaining funding for innovative programs
- Cultivate private funder relationships
- Increase funding to CCH year over year

Leverage Valuable Assets
FY2020-2022 Strategic Planning Recommendations

Support a learning health system – Convener for CCH Innovation Center

- Quarterly Research and Innovation Summits
- Publish quarterly issue briefs
- Quarterly newsletter update
- Quarterly trainings

Secure research funding

- Identify + meet with interested clinicians
- Secure research grant

Impact Social Determinants/Advocate for Patients FY2020-2022 Strategic Planning Recommendations

Cultivate external partnerships

- Participate in strategic committees
- Secure additional patient resources

Foster systematic change to support health equity

- Develop cross system partnerships
- Partner with Collaborative Research Unit

Thank you.

COOK COUNTY HEALTH

ATTACHMENT #3

Strategic Planning FY 2020-2022

Correctional Health: Adult and Juvenile

Linda Follenweider, Chief Operating Officer

February 28, 2019

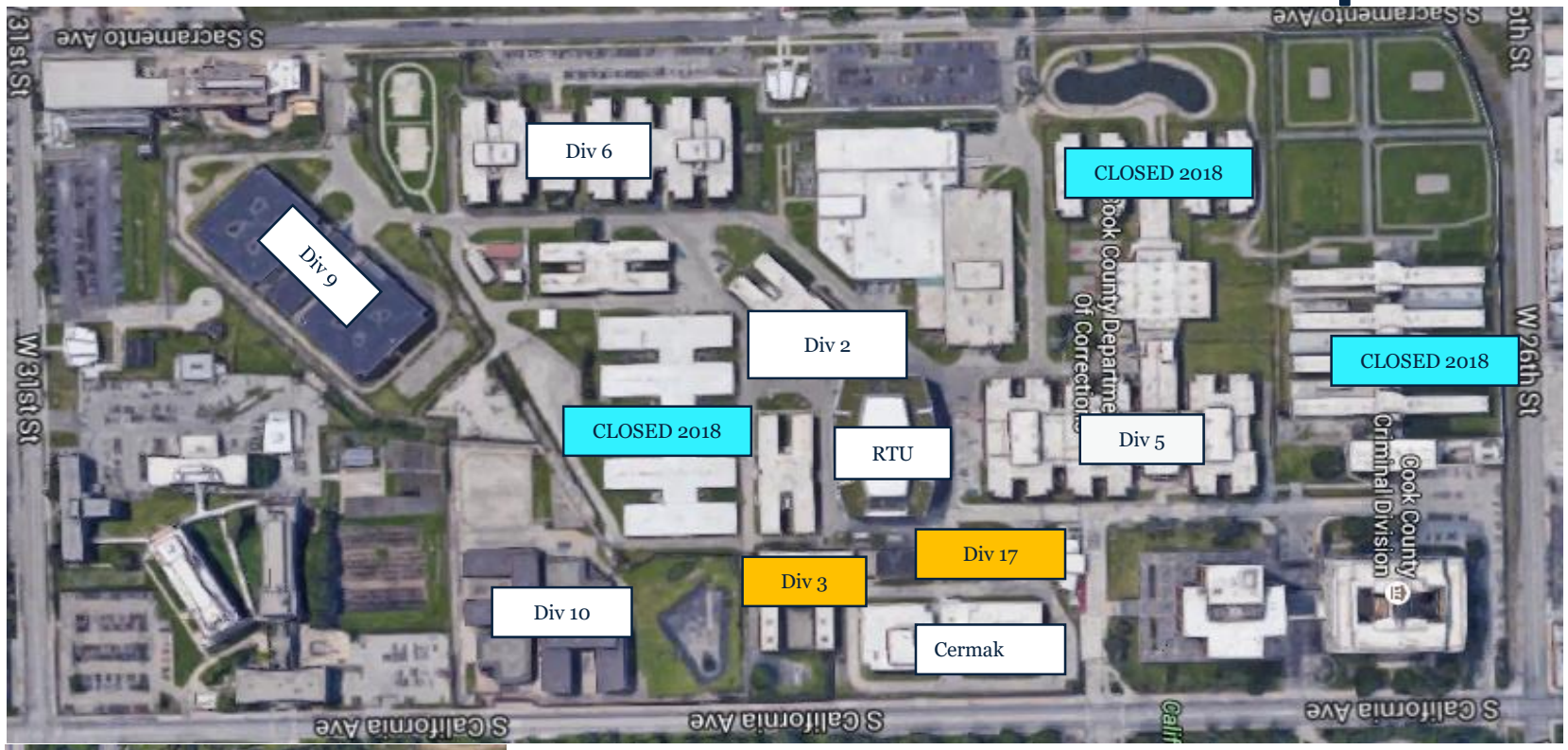
COOK COUNTY HEALTH

CCH Correctional Health

Operations and Services Overview

COOK COUNTY HEALTH

Cermak Health Services: Adult Campus



96 Acre Cook County Jail Campus
Currently 8 Buildings used as living areas by CCDOC (**Orange**=demolished; **Green**= closed)
Approx. 6000 Avg. Daily Population Housed On-Campus
Medical Dispensary in each living unit
On-Site Pharmacy
24/7 Urgent Care
Dialysis center
PT/OT department

Services by Division:
All:
- Primary Care Clinic
- Health Service Requests
- Dental
- Lab
- Mental Health Services
- Access to Urgent Care and Specialty clinics

Division 2 and 11
- All above plus
- Keep on Person Medications

Division 6, 9, 5 and 10
- All above plus
- Nurse Medication Pass

Division 8 (RTU)
- All above plus
- 24 hour nursing care
- Medical Detox
- CPAP

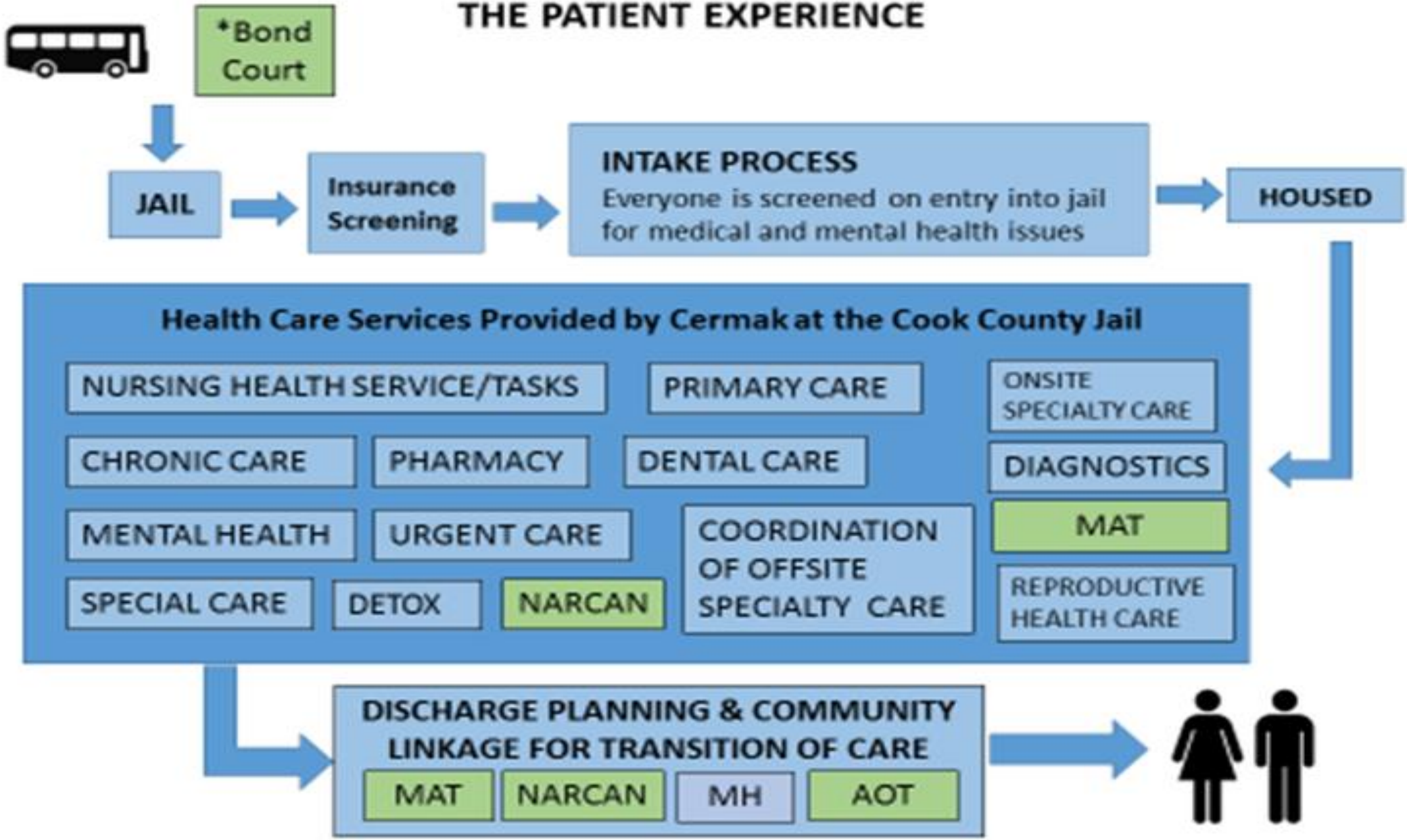
Division 8 (Special Care Unit)
- All above plus
- Highest service level for mental health and medical

COOK COUNTY HEALTH

CCH Correctional Health Services

- 24-hour **Urgent Care**/ paramedic response teams
- 24-hour **Special Care Units –** (medical and psychiatric, approx. 80 beds each)
- 24-hour **crisis mental health** team
- **Detox Unit** for patients **at risk** for ETOH/benzo and opioid withdrawal
- **Medication Assisted Treatment for Substance Use Disorders**
- On-site **specialty clinics** includes most commonly accessed services
- **Radiology**, including X-rays, CAT Scans, ultrasound
- **Hemodialysis unit (Monday, Wednesday, and Friday)**
- **Physical Therapy/Occupational therapy-** not Acute Rehab
- **Infection Control** Prevention and Control

THE PATIENT EXPERIENCE



Behavioral Health

CCHS Correctional Health provides a wide range of onsite services including:

- Mental Health screening & assessment
- 24-hour crisis intervention and stabilization
- Psychiatric services
- Therapeutic treatment services
  - Individual counseling and supportive psychotherapy
  - Group counseling and psychoeducation
  - Community linkage
- Involuntary medication petitions

Jail Population Decrease Impact on Mental Health Caseload

Mental Health Caseload

2016 2,000 patients or 23% total population (8,300)

2017 2,100 patients or 27.0% total population (7,400)

2018 2,123 patients or 35.6% total population (5,921)

Substance Use Disorder Treatment: Narcan

Cermak Rx - Naloxone Dispensing Program Summary							
Week	# Rx Educated	Sheriff Handout @ D/C		Monthly TAT - Edu to Dispense (day)			
		# Received	# Refused	Avg	Max	Min	Median
Aug - Nov 2016	201	36	14				
Dec - Nov 2017	1699	1034	3				
December-17	199	158	0	75	425	1	29
January-18	297	175	0	50	482	0	11
February-18	233	167	0	70	541	0	14
March-18	284	199	1	54	585	0	26
April-18	268	212	0	85	490	0	19
May-18	286	201	0	91	593	0	23
June-18	299	170	0	107	633	0	36
July-18	307	224	0	103	728	0	35
August-18	262	221	0	118	693	0	41
September-18	215	190	0	123	716	0	49
October-18	230	196	0	130	733	0	53
November-18	203	187	0	161	749	0	73
December-18	171	149	0	189	789	0	143
Total =	**5154**	**3519**	**18**	**87**	**789**	**0**	**25**

COOK COUNTY HEALTH

Physical Medicine

- Provider Visits approximately 7,000 per month
    - Primary Care ~1,400 per month
    - Medical Special Care Unit > 500 per month
- Urgent Care Visits > 1,300 per month
- Secondary Screening Visits > 1,300 per month

Physical Medicine

CQI STATISTICS & PERFORMANCE INDICATORS	INDICATOR	< / > / =	GOAL	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPT	OCT
CHRONIC CARE	TITLE												
GENERAL	TITLE												
# of Patients with DM	STATISTIC			246	238	247	236	216	235	221	216	223	213
# of Patients with ASTHMA	STATISTIC			819	890	867	859	829	939	929	922	928	914
# of Patients with HTN	STATISTIC			727	735	730	695	673	765	731	708	715	706
# of Patients with SEIZURES	STATISTIC			138	153	153	151	150	177	150	157	170	162
DEGREE OF DIABETIC CONTROL AS MEASURED BY LAST HGA1C AMONG PATIENTS INCARCERATED >120 DAYS	TITLE												
Good <7	STATISTIC			57.3%	51.1%	53.0%	52.2%	57.4%	61.9%	60.4%	57.7%	58.3%	65.6%
Fair 7-8 (<8)	STATISTIC			15.4%	12.8%	16.0%	15.7%	17.7%	20.2%	15.4%	19.5%	17.4%	19.2%
Fair 8-9	STATISTIC			14.0%	19.9%	18.2%	13.4%	9.6%	8.2%	8.1%	11.4%	14.8%	8.0%
Poor >9	INDICATOR	<=	20%	13.3%	16.3%	12.8%	15.7%	15.4%	9.8%	16.1%	11.4%	9.5%	7.2%

Nursing Services

CQI STATISTICS & PERFORMANCE INDICATORS	INDICATOR	</>/=	GOAL	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER
MEDICATION ADMINISTRATION	TITLE												
# of Scheduled Meds Administered	STATISTIC			241,568	221,005	246,758				255,279	255,369	251,513	252,500
# of PRNs Administered	STATISTIC			16,012	14,264	14,731				15,085	16,363	16,195	16,089
Given / Ordered (minus refusals)	INDICATOR	>=	90%	94.7%	94.8%	95.2%				94.5%	95.0%	95.5%	95.2%
# of refusals	STATISTIC			24,990	22,852	26,244				28,882	30,877	30,987	28,466

Offsite Specialty Services

CQI STATISTICS & PERFORMANCE INDICATORS	INDICATOR	< / > / =	GOAL	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPT	OCT
SCHEDULING - OFFSITE	TITLE												
Total # of Offsite Clinic visits scheduled	STATISTIC			345/477	333/478	410/540	360/473	376/510	316/432	359/481	395/553	339/472	386/521
# of Patients sent to Oral Surgery	STATISTIC			55/76	56/85	53/83	58/80	44/66	47/63	50/66	54/81	51/70	51/71 (72%)
# of Patients sent to ENT				27/41	34/42	37/48	38/37	38/51	24/36	22/31	22/28	15/18	21/31 (68%)
# of Patients sent to Hand Clinic	STATISTIC			32/44	21/25	29/45	33/42	28/32	14/19	21/30	33/37	23/30	22/27 (82%)
Specialty Clinics Appointments Kept minus refusals	INDICATOR	>=	90%	87.8%	84.7%	89.9%	90.9%	90.8%	91.6%	89.7%	88.6%	91.4%	91.5%

Top 3 Referrals

CQI and Risk Management

- Expansion of DASA License obtained which allows us to expand our MAT services
- Nursing Quality and Safety Committee which was established in October 2017
- All Staff completed High Reliability Training
- Nurse Radio Project
- Hired new position for Manager of Clinical Excellence & Performance Improvement.

Women's Health

- Approximately 10% of census (aprox. 600-700)
- Primary care clinics in all women's divisions
- STI evaluation (speculum exam etc) offered to all females within 2 weeks of arrival in jail
- Perinatal Service – prenatal clinic for pregnant and postpartum women
- Family planning services (under CCH Family Planning)
- Gyne Clinic weekly – colposcopy on site
- US – OB for dating only, no endovaginal probe
- Referrals to Stroger for MFM

Women's Health Services (continued)

- Comprehensive family planning services are offered to women pre-release, including the provision of long-acting reversible contraceptive methods.
- Office of Women's Health of Illinois Dept of Public Health provided training and implementation support.
- CCH Family Planning oversees, administers grant funds, collects and reports data

Patient Feedback

"My goals: get released from jail, stay clean, live a normal life, have a healthy pregnancy"

"I have received more medical care here in the past 6 months than I have in my whole life."

"I wouldn't have followed up for birth control on the outside, I'm glad I'm getting it done now."

"I think it's good for me to leave jail with birth control because I want to take time with my three daughters and gain our bond back. I don't need another baby until I am stable and with my life back on track."

Patient Feedback

One woman planned to ask her judge for an extension of her stay in order to get her IUD placed before release. Luckily, this was not needed.

“I'm an addict… and while I work on figuring that part of my life out the last thing I need is to get pregnant. Getting a Nexplanon is the most responsible thing I've done in my life.”

"The staff and services were excellent. It really means a lot to me and will help my recovery now that I don't have to worry about birth control."

"Getting birth control before I left CCDOC was very important to me. Now I can focus on my two young children and getting back to school and my future. Thank you so much!”

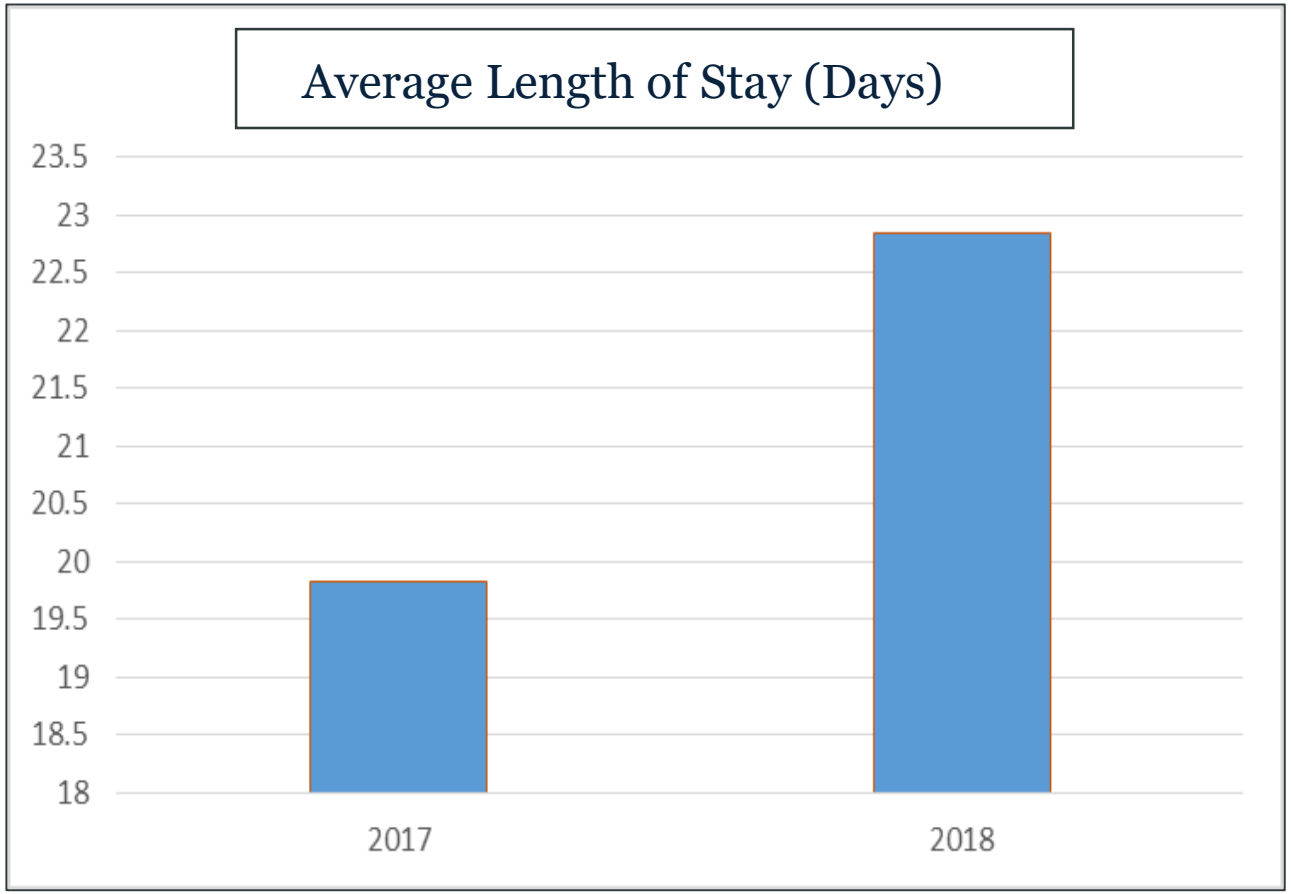
Radiology

CQI STATISTICS & PERFORMANCE INDICATORS	INDICATOR	< / > / =	GOAL	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPT	OCT
RADIOLOGY	TITLE												
# of screening xrays	STATISTIC			2,857	2,562	3,191	2,840	3,371	3212	3,330	3,267	2,988	2,956
CT scans	STATISTIC			119	92	120	92	139	98	111	112	77	124
US's done	STATISTIC			68	68	86	69	102	69	81	92	68	69
Echo's done	STATISTIC			38	30	6	46	31	41	41	41	38	56
General X-rays	STATISTIC			799	631	629	682	671	585	591	666	576	633

Juvenile Temporary Detention Center

- Provides a safe, secure, structured temporary residency for youth ages 13-21 with pending legal action in the Cook County Court System
- Five story, six level facility, the largest free standing juvenile detention center in the nation
- 600 employees
- The functional capacity is 382. Average Daily Census 180.

Juvenile Temporary Detention Center



On Site Services

- Educational services
- 24 hour nursing care
- Pediatricians
- Dental services
- Psychiatrists
- Psychologists
- Mental Health Specialists
- Clinical Social Workers
- Case Management

JTDC Milestone Activities

April 17, 2016 – RMIS Go-Live *(Resident Management Information System)*

September 26, 2016 – Cerner electronic medical records Go-Live

February 28, 2017 – Onsite ECG

March 1, 2017 – onsite Pediatric Cardiology

April 17, 2017 – KOP expansion

June 19, 2017 – Dentrix electronic dental records

June 26, 2018 – 1st Chicago Run Program at JTDC *(2nd in 10/27/18)*

August 28, 2018 – Transition of Behavioral Health Services from NU to CCH

October 10, 2018 – Transition Planning re: AT residents transfer to DOC

October 30, 2018 – 2nd Breast Cancer Awareness Program

November 2, 2018 – Telepsychiatry, Fridays 1:00-4:00 p.m.

November 5, 2018 – Return of Art Therapist at the JTDC facility for Murals Program

Impact 2020 Recap

Status and Results

- Deliver High Quality Care
- Grow to Serve and Compete
- Foster Fiscal Stewardship
- Invest in Resources
- Leverage Valuables Assets
- Impact Social Determinants
- Advocate for patients

COOK COUNTY HEALTH

Impact 2020

Progress & Updates

Focus Area	Name	Status
Nurse Radio Project	Nursing staff received radios to be able to contact from anywhere on campus	Complete
Scheduling automation by location and clinic	Using Cerner EMR to notify CCDOC of scheduled appointments and clinic visits	Complete
HSRF project	Using Cerner EMR and logic to improve HSRF process	In progress
Passed DOJ	May 2018	Complete
Completed High Reliability training	System initiative for patient safety culture	Complete phase one all staff training

HSRF: Health Services Request Form

Impact 2020

Progress & Updates

Focus Area	Name	Status
Efficiencies in Lab services (decentralized)	Moved lab draws out to divisions and trained nursing staff	Complete
Eliminated Medication software vendor for Cerner (one record)	Accuflo contract ended in July 2017	Complete
Converted from paper to EHR JTDC	Eliminated paper EMR	Complete
Awarded BH services at JTDC	Integrates care with CCH	Complete
Passed NCCHC recertification at JTDC	February 2019	Complete

Impact 2020

Progress & Updates

Focus Area	Name	Status
MAT license expanded	To include suboxone and maintenance	Complete
Narcan program	Started in August 2016 and expands each month	On going
Assumed CPAP equipment and staff	New Respiratory Therapist provides in house CPAP management and expansion of education and monitoring of patients with respiratory needs.	Complete
Expanded grievance services	Includes patient visits with RN	Ongoing

FY2020-2022

The Future

Environmental Scan of Market, Best Practices and Trends

COOK COUNTY HEALTH

Environmental Scan of Market, Best Practices, Trends

- Share our best practices and innovations with other jails as recommended by DOJ including Women's Health, Grievance process,
- Telehealth:
  - Behavioral Health telehealth assessments
  - Behavioral Health and MAT telehealth visit with Stroger and Provident provider
  - Wound care rounds for nurse training with face time
  - Round table with experts and detainees
- Behavioral Health and Medication Assisted Treatment expansions
- Transitions in Care:
  - Nurse Navigator
  - Return to community: expanding warm handoffs
- Nursing training:
  - Use SIM Lab for common exams and special exams setting specific

Legend

Current Project
Future Project

Juvenile Temporary Detention Center (JTDC)

Community partnerships and linkages post discharge

- Partner with community agencies in providing sexually transmitted infection education to the residents.
- Link soon-to-be-released residents to their primary care provider by providing a summary of health services they received at the facility for continuity of care.

Healthy JTDC 2020

- On-going 3K Chicago Run
- Parenting Classes
- Health Awareness Presentations: Breast Cancer, HIV, Lupus, Lung Cancer
- Smoking Cessation Classes for staff

Maintain NCCHC Accreditation (successful 2019 survey)

National Commission on Correctional Health Care – leading national organization dedicated to improving the quality of health services provided in correctional institutions.

SWOT Analysis

Strengths, Weaknesses, Opportunities, and Threats

COOK COUNTY HEALTH

SWOT Analysis

Strengths	Weaknesses
• Connection to system/shared EMR • High Reliability culture expectations • Dedicated high caliber clinical staff • Better care creates healthier community • Early identification of problems through intake screening	• Staffing challenges • Grey zones with roles and responsibilities in a complex, high-risk environment • Infrastructure challenges (plant and physical structures) • Unpredictable discharge that is unrelated to clinical needs
Opportunities	**Threats**
• Care transitions • Ground zero for Opioid crisis • Expanding telehealth • Share DOJ identified national best practices with other jails nationally • Solidify JTDC services in jail and community with new positions and focus • Strengthen DOC partnership	• Highly litigious atmosphere • Older and sicker incarceration trends • Detainee stigma (societal) • High cost therapeutics and other medications • Longer stays

FY 2020-2022

COOK COUNTY HEALTH

Deliver High Quality Care
FY 2020-2022 Strategic Planning Recommendations

- Continue with High Reliability Journey to deliver safe, high quality care
- Expand transition into the community services through partnerships with CCH care management and PCMH providers

Foster Fiscal Stewardship
FY 2020-2022 Strategic Planning Recommendations

- Improve process for risk avoidance and mitigation
- Data dashboard expansion to inform care and create efficiencies

Invest in Resources
FY 2020-2022 Strategic Planning Recommendations

- Moving Correctional Focused Training to LMS system
- Trauma informed Care training
- PREA training

Impact Social Determinants/Advocate for Patients FY 2020-2022 Strategic Planning Recommendations

- Medication Assisted Treatment
- Medicaid enrollment
- Expanding Electronic Monitoring with stable housing

Thank you.

COOK COUNTY HEALTH

ATTACHMENT #4

Strategic Planning FY 2020–2022

Behavioral Health

Diane Washington, MD
Executive Director of Behavioral Health

February 27, 2019

COOK COUNTY HEALTH

CCH Vision 2015

A Comprehensive Behavioral Health Network

Develop a continuum of care across the current health system and other partners that expands access and fills current gaps

Build shared operations and infrastructure that will enable the BH Network to effectively manage services that will improve population health, and health outcomes

Support the ability of partners to improve quality of services offered and strengthen the system of care, reducing use of inpatient, emergency department, and correctional beds

Impact 2020 Recap

Status and Results

- Deliver High Quality Care
- Grow to Serve and Compete
- Foster Fiscal Stewardship
- Invest in Resources
- Leverage Valuables Assets
- Impact Social Determinants
- Advocate for patients

COOK COUNTY HEALTH

Impact 2020

Progress and Updates

Focus Area	Name	Status
Deliver High Quality Care	CCH Department of Psychiatry to resume consulting services in the Emergency Room	Complete • Hired CCH employees to staff ED
Deliver High Quality Care	Explore opportunities to reduce the jail population	Ongoing • Opened two Triage Centers • Vivitrol and Naloxone programs at the Jail
Grow to Serve and Compete	Work with local, state and federal stakeholders to streamline the care transition process for justice-involved populations to prevent gaps in care	Ongoing • Support collaborations for linkages of care/Care Coordination at both JDTC/CERMAK

Impact 2020

Progress and Updates

Focus Area	Name	Status
Grow to Serve & Compete	Behavioral Health Consortium to support Transition of Care to fill gaps in care as continuum of BH services across CCH Provide wrap-around services for vulnerable patients-uninsured, SMI, etc.	Ongoing
Foster Fiscal Stewardship	Implement full billing for behavioral health	Ongoing • LCSW to begin billing for services
Deliver High Quality Care	Integrate and expand additional services, especially in outpatient health centers including behavioral health (mental health and substance abuse)	In progress • Addition of psychiatrist to all Ambulatory Clinics for 1-day /week something we have done • LCSW case managers will be assigned to cover regional areas

Impact 2020

Progress and Updates

Focus Area	Name	Status
Deliver High Quality Care	Establish an integrated continuum of behavioral health services throughout CCH, including CountyCare	In progress • Transition of Care collaborations • Behavioral Health Consortium • Care coordination for Behavioral Health needs across CCH
Deliver High Quality Care	Integrate behavioral health practice management tools within the electronic medical record	In progress • Templates to be used for consistent documentation • Streamline screening tools to reduce redundancy of information collection.
Leverage Valuable Assets PCP-BH Integration	Phase 1&2 Initiation of staff and resources; conceptual planning with some implementation.	Complete • Phase 1, Initiation • Phase 2, Planning In progress • Phase 3, Implementation

FY2020–2022

The Future

Environmental Scan of Market, Best Practices and Trends

COOK COUNTY HEALTH

CCH Vision

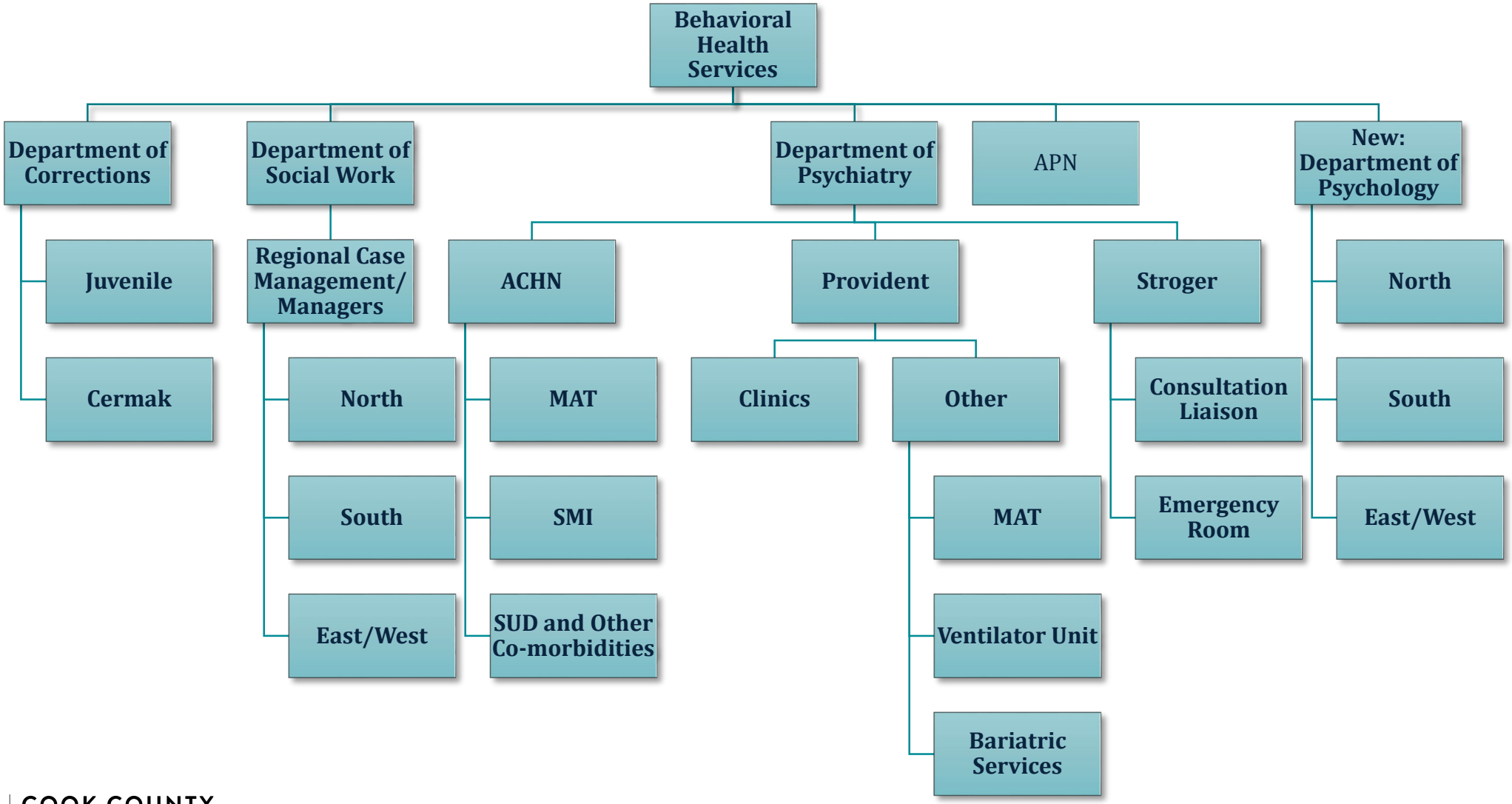
A Comprehensive Behavioral Health Network

Lead the continuum of BH services across CCH with focus on the most vulnerable patients where collaboration with other partners (internal/external) are paramount to increase access to care, fill gaps & improve health

Build a more solid Infrastructure to enable BH Network expansion and synergize shared operations to improve access, wrap around services, address homelessness, health + patient experience

Identify the capabilities of providers & partners to improve access, quality, value, and fiscal responsibilities to strengthen care across CCH by reducing wait lists, no show rates, hospital beds, ED visits

Behavioral Health Services at CCH



Environmental Scan of Market, Best Practices, Trends

Innovative tools required to support our current business trend by providing value

Tele-psychiatry

More than 80 million millennials will comprise a larger pool of behavioral health. Treatment centers will need to shift to appeal to this digitally connected population

- Tele-psychiatry as a tool to increase access to care, delivery of real-time services, fast and efficient which decreases waiting lists and no-show rates, ultimately increase provider productivity and improved quality care.
- In Ambulatory clinics
- In Corrections –Juvenile Treatment Detention Center (JDTC) and Cermak Health
- In Behavioral Health Consortium (BHC) agencies
- In Stroger Hospital
- Cerner tele-psychiatry platform build is required to support services across of CCH plus information sharing rights and template building tools for documentation of services, scheduling, staffing as well as the continual management.

Environmental Scan of Market, Best Practices, Trends

Innovative tools required to support our current business trend by providing value

Addiction Medicine

- Addiction Treatment ("Opioid Crisis")
- Addiction Medicine - Partnering Program at CCH
- Leverage internal expertise and build-in external expertise where needed
- Expand partnerships to support and collaborate on specific care and redundancy of addiction services. Examples include:
  - University of Illinois
  - RUSH
  - Mount Sinai
- Leverage grant opportunities to support:
  - infrastructure program build
  - training/education
  - other ancillary services (wrap-around services)
- Develop a formal Medication Assisted Treatment with full Level 1, 2, & 3 interventions
- Develop construct of Centers of Excellence in Addictions through partnership engagements

SWOT Analysis

Strengths, Weaknesses, Opportunities, and Threats

COOK COUNTY HEALTH

SWOT Analysis

Strengths

- Excellent model for primary care provider-behavioral health integration
- Model for integration continues to grow
- Model is the national and global best practice for the future of Behavioral Health delivery
- Strong Grants Research & Development-dedicated partners
- Good internal stakeholders collaborations: CountyCare & Integrated Health, Ambulatory

Weaknesses

- Current Behavioral Health Services across CCH lack a cohesive structure for consistency of patient care
- Lack of tools, billing, IT templates, workflows/plans, algorithms, and Standard Operating Procedures to support expanded CCH business
- Thin infrastructure development to support full MAT (behavioral interventions) certified treatment programs

Opportunities

- Build Tele-psychiatry/Telehealth services across CCH for innovative way to provide real-time BH
- Build infrastructure to support expansion of Medication Assisted Treatment by evaluating customer needs and outcomes parameters
- Leverage grants/initiatives to support key objectives for building MAT infrastructure, improve homelessness, promote sustainability of efforts

Threats

- Weakly defined roles and responsibilities lead to lack of continuity of care
- Understanding of impact of productivity on finances and billing/fiscal stewardship
- Understanding the role of value in our service delivery

FY2020–2022

Innovation is the Future of Behavioral Health

COOK COUNTY HEALTH

Illinois Behavioral Health Transformation

Department of Health and Family Services

Section 1115 Demonstration waiver proposed critical next steps:

Goals:

1. Rebalance the behavioral health ecosystem, reducing over-reliance on institutional care and shifting to community-based care
2. Promote integrated delivery of behavioral and physical health care for behavioral health members with high needs
3. Promote integration of behavioral health and primary care for behavioral health members with lower needs
4. Support development of robust and sustainable behavioral health services that provide both core and preventative care to ensure that members receive the full complement of high-quality treatment they need
5. Invest in/Partner to attain support services to address the larger needs of behavioral health members, such as housing and employment services
6. Create an enabling environment to move behavioral health providers toward outcomes- and value-based payments

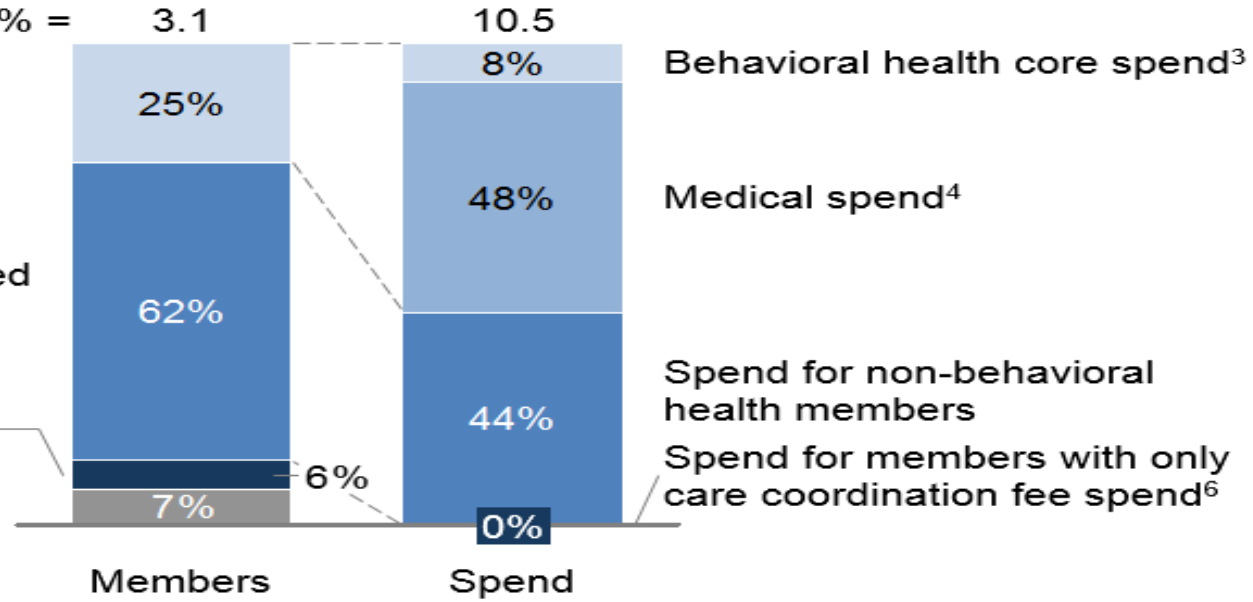
CCH systems and strategies closely align to these State goals

Illinois Behavioral Health Transformation 2015

Medicaid members with diagnosed and/or treated behavioral health needs make up 25% of the population, but 56% of the total spend

FY2015 members and spend[1,2]

Annualized members (millions), dollars (billions)



1 Annualized members (not unique members) shown here with no exclusions made on population or spend. Annualized member count = Sum of member months/12
2 Most inclusive definition of behavioral health population used here of members who are diagnosed and treated, diagnosed but not treated, and treated but no diagnosis present. Behavioral health core spend defined as all spend with a behavioral health primary diagnosis or behavioral health-specific procedure, revenue, or HIC3 pharmacy code.
3 Behavioral health core spend is defined as spend on behavioral health care for individuals with behavioral health needs
4 Medical spend is defined as all other spend for individuals with behavioral health needs. See appendix for additional methodology notes
5 Behavioral health diagnosis is defined as a behavioral health diagnosis in any of the first 18 diagnosis fields of any claim during the year. Behavioral health treatment is identified on the basis of a claim with a behavioral health primary diagnosis or a behavioral health-specific procedure, revenue, of HIC3 drug code during the year
6 Annualized members with only spend for care coordination fees. Care coordination fee is identified by HCPCS codes - G9002, G9008

SOURCE: FY15 State of Illinois DHFS claims data

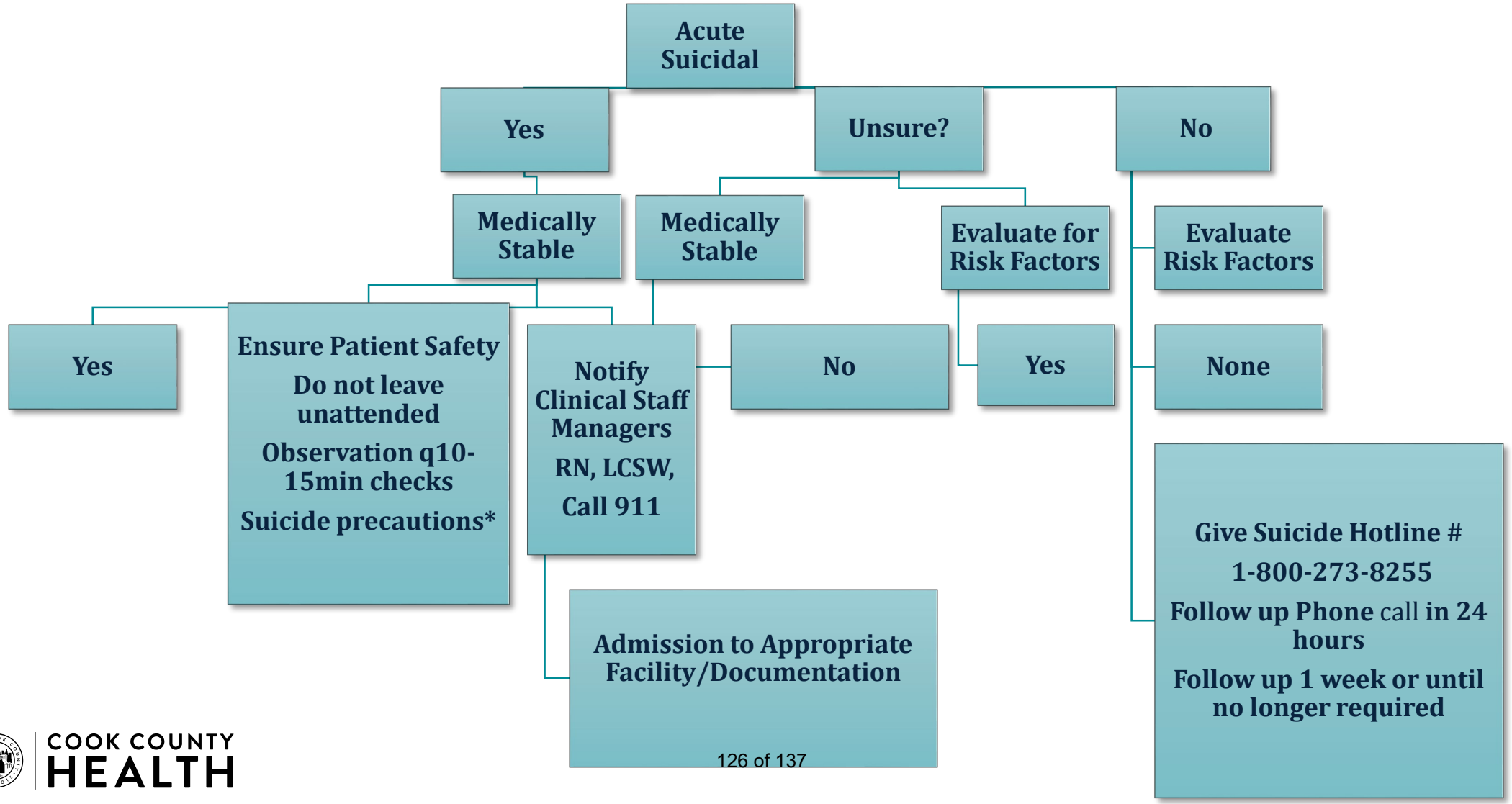

1
Initiating Process
2
Planning Process
3
Executing Process
4
Monitoring & Controlling Process
5
Closing Process
PROJECT LIFECYCLE

Deliver High Quality Care
FY 2020–2022 Strategic Planning Recommendations

Primary Care Physician and Behavioral Health Integration

- Phase 1 and 2 are complete
- Phase 3 requires developing infrastructure to solidify operations: identify barriers, define provider roles and responsibilities, develop tools to support workflow, algorithms and build consistency across all ambulatory health centers, implement a culture of collaboration, identify best practices, institute training programs, resolve State policies that hinder reimbursement, consider other value added resources of Family/Marital Counseling to support areas that require more intensive therapies, form multidisciplinary team approach to shared-care responsibility model
- Phase 4 requires testing and monitoring processes put in place and analyzing data, outcomes, identify value added services and HEDIS (Health Effectiveness Data and Information Set) measures, fill gaps in delivery of care, workflow obstacles-test and continue tracking and trending data
- Phase 5 -Full integration- Barriers resolution, gaps filled, measures support improved patient outcomes, increase patient access to care, increased provider productivity, reduce reimbursement issues, improve quality/value added services

Consistent Patient Care Processes -- Suicidal Ideation Example
Acutely Suicidal Algorithm Draft



COOK COUNTY HEALTH

Deliver High Quality Care
FY 2020–2022 Strategic Planning Recommendations

PCP and BH Integration – Medication Assisted Treatment

- Expand Medication Assisted Treatment into a comprehensive substance abuse program with integral Behavioral Health Services to support opioid treatment :Level 1, 2, & 3. as well as other substance use disorders (SUD)/Severely Mentally Ill (SMI) patient care.

Potential Centers to be designated as Centers of Excellence:

- **Prieto**- Currently provides Alcohol, Opioid, and Smoking cessation services
- **Austin**-Currently has comprehensive structure that can be leveraged to provide and even greater continuum service with Psychiatry and Westside Community Triage Centers for (Substance Use Disorders)
- **CORE**-Currently has an excellent delivery of care via case coordination of services for HIV, and Substance Use Disorders-most comprehensive model of care

PC–BH Integration Implementation Status and Successes

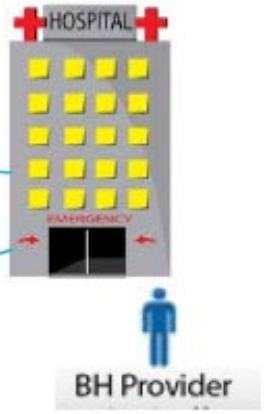
Grow to Serve and Compete
FY 2020–2022 Strategic Planning Recommendations

Behavioral Health Consortium

12 member-based organization originally identified in 2015 to augment CCH community Behavioral Health services

- Improve capacity to support CCH business
- Identify strengths and weaknesses of each Behavioral Health Consortium member
- Enhancement tools to measure quality and data analysis to transition of care
- Patients lost to follow up, delivery of care to the uninsured, patient experience etc.
- Optimize BHC services to support CCH expenditures by evaluating operations and processes to identify gaps, billing, redundancies/duplication scope of work, enhancement of cost cutting measures, justification and reconciliation
- Quarterly meetings to provide data analysis (HEDIS + others parameters) to each member to evaluate and monitor deliverables

Behavioral Health Consortium



CCHHS Behavioral Health Continuum of Services

Foster Fiscal Stewardship
FY 2020–2022 Strategic Planning Recommendations

Dept. of Psychiatry, Dept. of Social Work, Behavioral Health Consortium, Community Triage Centers

- **Improve Access**: Add providers to specific sites to assist with immediate need, decrease waiting list/ backlog, build in efficiency tools: Regularly scheduled structured groups, tele-psychiatry/health, mobile crisis units
- **Improve Quality**: Provide oversight for each Behavioral Health Consortium member and evaluate each member capabilities or capacity to support the current and future needs of CCH + CountyCare business with concrete metrics to support
  - Current deep dive and monitoring of each member capabilities and analysis of fiscal yield per each member, adding more concrete parameters (Health Effectiveness Data and Information Set) HEDIS measures) to evaluate performance
- **Increase Provider Productivity**: Set expectation of daily volume of patient visits, offset no show rates and scheduling services to support this rate, decrease wait lists/backlog
  - Decrease redundancies for delivery of services, support consistency via workflows, algorithms, templates. processes and policies
  - Reduce hours of operation costs for Community Triage Centers by developing collaborative hospital partnerships

Invest in Resources
FY 2020–2022 Strategic Planning Recommendations

Assertive Community Treatment

- Partner with Integrated Health and CountyCare, external partners
- Transition of Care
  - Tackling "Homelessness" Crisis
    - Most vulnerable: Severe Mentally Ill (SMI); SMI+SUD, MMI (Prevention)
    - Develop Community Integrated Living Arrangement (CILA) like temporary housing for up to 6 months while recovery and treatment becomes solidified
    - Implement Care Coordination Teams

  - Require wrap-around services:
    Medication Management/Medical/Nutritional Support

  - Resources needed: Care Coordinators, Community Health Workers, Health Educators, and Mental Health Workers

Leverage Valuable Assets
FY 2020–2022 Strategic Planning Recommendations

PCP/BH Integration

Expand the use of the PCP-BH model to maximize efficiencies and create best practices

- Align services to support framework of multi-discipline team huddles
- Continue to build this model with more Behavioral Health and more direct involvement of psychiatrists and regional positions of case managers (LCSW) and psychologists
- Use measurement tools to monitor and support processes that improve value, quality, patient experience, utilization of services and patient outcomes
- Build the use of telehealth/tele-psychiatry to further support the integration process
- Educational/Training programs to leverage and support expansion of this model (e.g “lunch and learn”)
- Utilize opportunities to learn from others on National & Global level how this model can supports the delivery of comprehensive BH patient care

Impact Social Determinants/Advocate for Patients FY 2020–2022 Strategic Planning Recommendations

Integrated Health, CountyCare, Collaborative Care Partners

Assertive Community Treatment (ACT)
Primary Objective: Reduce Homelessness
Requires multi-level collaboration strategies for resourcing:

- Partner with other local partners to develop and build more collaborative patient models
- Engagement of community advocacy partners
- Ensure interphases with Integrated Health, CountyCare, and ACHN sites
- Advocate for resources for the need for Community Healthcare Workers who are the direct link to continuity of care
    - Resources should be multi-factorial and spread across all partners
    - Update all intake templates to support evaluation of the social determinants and actions to be taken to assist in linkages to address these needs
    - Grants- identify those that address any elements of social determinants

CCH Behavioral Health Initiatives

AMBULATORY

- Collaborative Care Model for Medication Assisted Treatment
- Improve (infrastructure) for Expand (MAT)
- Added Recovery coaches & Psychiatrists

CARE MANAGEMENT

- Expanded CM teams to include BH expertise for TOC
- Streamline Behavioral Health Consortium services
- Behavioral Health Access Line (BHAL) valued added improvements

DEPARTMENT OF PSYCHIATRY

- Dept. of Psychiatry to provide services to all ACHN 1/day week
- Added Dept. of Psych to lead BH Education/Training
- Telepsychiatry services via IT CERNER to promote BH efficiencies, patient access and cost savings

COUNTYCARE

- Current Initiative to improve BH transitions of care process
- Integrative Management of BH services
- (HEDIS) Health effectiveness and Data Information Set and other measures to direct services

GRANT DEVELOPMENT OFFICE

- Novel Grant: BH Grant- for Children with Chronic Disease – MEND Biopsychosocial Model Loma Linda Univ.
- Grants awarded or continued in the SUD Disorders, Diversion
- Several grant applications pending worth $$$$$$$

Next Steps

Additional staff to support BH overall strategy

- Continued implementation of strategy and integration of behavioral health initiatives across CCH

Oversight, Monitoring, Implementation of Strategies to support BH

- Build infrastructure to expand Medication Assisted Treatment/addiction services
- Reframe Behavioral Health Consortium: scope of work, build hospital collaboration network, improve care coordination efforts
- Use performance indicators, quality, value-added measures, fiscal stewardship for BH programs
- Use data analysis tools to support monitoring patient care delivery and provide reports displaying tracking trends for process improvements

Continued Focus on Collaborations with CountyCare and Community Partnerships

- Improve Transitions of Care by continuing to identify and monitor the need for external resources to support expansion of this behavioral health initiative
- Juvenile Temporary Detention Center support/leverage Care Coordination services for justice-involved youth
- Evaluate partnerships for strategic implementation of BH goals
- Build incentives and leverage HEDIS/quality, value-based measures

Thank You

COOK COUNTY HEALTH